

Rhode Island Department of Health

Health Policy Briefs

Utilization Review in Rhode Island

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Utilization Review

Our health care system has continued its shift from "a pluralistic, fee-for-service system of independent practitioners to one characterized by consolidated, capitated systems based on integrated networks of managed care."¹ This shift is an attempt to contain rising health care costs.

Managed care organizations employ utilization review (UR) to control costs and assure quality care. UR is a "formal assessment of the medical necessity and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis."² In Rhode Island, a health plan may perform UR itself, or it may contract with a separate company specializing in utilization review.

The Appeals Process

Under the Rhode Island UR Act of 1992, patients, physicians, and other health care providers have the right to appeal adverse determinations. An adverse determination is "any decision by a review agent not to certify an admission, service, procedure, or extension of stay ordered by an appropriately licensed provider."³ There are three potential levels during the appeals process. The first two levels of appeals are internal, that is they are conducted within the UR agency. An "internal appeal means the procedure provided by the review agency in which either the patient or the provider of record may seek review of decisions not to certify an admission, procedure, service, or extension of stay."⁴ The second appeals process is offered in those cases where an initial appeal is unsuccessful. "In cases where a second level of internal appeal by the utilization review agency fails to reverse the original decision, the utilization review agent shall provide for an external appeal by an unrelated, objective agency."⁵ "Decisions rendered by the external appeals agency are final and binding upon the review agent."⁶

Costs for the first two levels of the appeals process are covered by the health plans. In the case of external appeals, costs are shared equally by the health plan and the party who appeals.

The purpose of the appeals process is to ensure the protection of patient rights and the ability of providers to order procedures covered under a health insurance agreement which are necessary for the treatment of the patient. Rhode Island law specifies that UR is the "prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider given or proposed to be given to a patient or group of patients."⁷ Retrospective utilization review activities are presently unregulated in Rhode Island.

A High Percentage of Appeals Result in Overturned Adverse Determinations

It has been argued that UR has the potential to diminish the quality of care administered by providers since managed care organizations have an incentive to deny treatments. In fact, of the 308,729 requests for approval from a UR agency, only 1.36% resulted in an adverse determination.

TABLE 1

Utilization Review	1997 Totals (%)	Per Cent Appealed of Adverse Determinations at Previous Level
Total Requests:	308,729	
Adverse Determinations:	4,208	1.36%
Level 1:	1,140 (100.00)	27.09%
· Upheld	635 (55.70)	
· Overturned*	470 (41.23)	
· Pending	35 (3.07)	
Level 2:	256 (100.00)	40.31%
· Upheld	162 (63.28)	
· Overturned*	79 (30.86)	
· Pending	15 (5.86)	
External:	59 (100.00)	36.41%
· Upheld	16 (27.12)	
· Overturned*	34 (57.63)	

· Pending	9 (15.25)	
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Of the 4,208 adverse determinations only 1,140 (27.09%) were appealed. A high percentage of adverse determinations at each level are overturned; 41.23%, 30.86%, and 57.63%, respectively were overturned at the first, second, and external levels. Moreover, only a very small percentage, 1.4% (59), of all initial adverse determinations resulted in the external appeals level process, with a high rate of overturned cases at the external appeals level (57.63%). In total, of the 1,140 adverse determinations which are brought to the first level of the appeals process, 583 cases, or 51.14%, were eventually overturned.

* The provider request is affirmed

Note: Data provided in Table 1 is not audited.

Conclusion

Only about one in four adverse determinations are appealed. This could reflect high rates of requests for unnecessary medical procedures, lack of knowledge about the appeals process, complex appeals processes, or other circumstances. Current health department activities under the UR law and the Health Plan Act help increase knowledge about the appeals processes for both providers and patients. Tracking the appeals information for health plans is an important source of data on access to care.

A next step to ensure consumer and provider protection should be to include retrospective UR in the appeals process.** Currently, appeals can only occur for prospective and concurrent adverse determinations, leaving a major gap in the financial protection of consumers and providers. In retrospective UR, the managed care organization can decide not to reimburse a provider for services already rendered. Such decisions may cause providers to be less likely to order services which have resulted in retrospective adverse determinations. With the inability to appeal, providers absorb or seek payment from the patient.

** There is a concern that retrospective UR is being used more frequently because there is no required appeals process.

For Additional Information on this Subject

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Sources

1. Patricia A. Nolan, MD, MPH, excerpt from a speech given on April 4, 1998
2. <http://www.uhc.com/resource/glossary.html#U>
3. RIGL 23-17.12-2(1)
4. Rules and Regulations for the Utilization Review of Health Services (R23-17.12-1-UR), 1.15
5. Rules and Regulations for the Utilization Review of Health Services (R23-17.12-1-UR), 7.1

6. Rules and Regulations for the Utilization Review of Health Services (R23-17.12-1-UR),
7.1.9
7. RIGL 23-17.12-2(8)

For more information about public health in Rhode Island, consult the Rhode Island Department of Health Website: www.health.ri.gov